STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38523 Based on observation and interview, the facility failed to ensure a urinary catheter bag had a privacy cover over it to maintain privacy and dignity for Resident #49. This affected one Resident (#49) of two residents (#49 and #64) who had urinary catheters. The census was 69. Findings include: On 01/17/24 at 12:25 P.M. observation of Resident #49 in the facility dining room eating lunch revealed his urinary catheter bag collecting urine was not in a privacy cover. Interview on 01/17/24 at 12:26 P.M. with Assistant Director of Nursing (ADON) #811 verified Resident #49 was eating lunch in the dining room and the urinary catheter bag did not have a privacy covering over it.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42730 Based on observation, staff interview, and facility policy review, the facility failed to ensure temperatures in the main dining room were kept at a comfortable level. This had the potential to affect seventeen residents (#5, #7, #15, #18, #19, #22, #23, #24, #27, #31, #33, #37, #39, #41, #47, #48, #377) the facility identified as residents who ate meals in the main dining room. The facility census was 69. Findings include: Observation on 01/17/24 at 4:36 P.M. in the main dining room, during the dinner meal, revealed a thermostat located on the wall adjacent to the windows. The thermostat was set to 68 degrees Fahrenheit (F) with a current temperature reading of 66 degrees F. Interviews on 01/17/24 at 4:38 P.M. with Residents #18, #23 and #31 revealed it was cold and sometimes uncomfortable while eating due to the the dining room not being warm. Observation and interview on 01/17/24 at 4:39 P.M. revealed Bookkeeper (BKR) #287 standing in front of the thermostat. BKR #287 revealed the thermostat was locked on a degree setting of 68 degrees F and had a current temperature of 66 degrees F. BKR #287 confirmed and verified the above findings at the time of the observation. Interview on 01/17/24 at 4:44 P.M. with Maintenance Director (MD) #804 and #805 revealed depending on the resident's preference, temperatures in common areas usually were set between 72 and 74 degrees F and usually set higher than 68 degrees F. MD #804 and #805 revealed temperatures in the facility should be set between 71 and 81 degrees F. According to the national and local weather forecast via www.weather.com, dated 01/17/24, the temperature for the facility's location revealed a high of 21 degrees F and a low of 18 degrees F. Review of the facility document titled Extreme Heat/Cold, revised January 2023, revealed the facility had a policy in place to provide a comfortable living environment for residents. Review of the policy revealed the temperatures within the facility and the resident areas would be maintained between 71 degrees F and 81 degrees F. Review of the document revealed the facility did not implement the policy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38523 Based on record review and interview, the facility failed to develop a baseline nursing care plan for Resident #75 according to the regulation requirement. This affected one Resident (#75) of 20 residents reviewed for care plans. The facility census was 69. Findings include: Record review revealed Resident #75 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including malignant neoplasm of oropharynx, drug induced pancytopenia, anemia due to antineoplastic chemotherapy, elevated white blood cell count, localized swelling, mass and lump of the neck and head, malignant neoplasm of prostate cancer, chronic kidney disease stage three, peripheral vascular disease and acute respiratory failure. Review of the admission assessment dated [DATE] revealed Resident #75's functional assessment was one person assist. He was partial weight bearing. He was oriented to time, place and person. Further review of the medical record revealed no evidence a baseline care plan involving Resident #75's needs for care and services had been developed within the first 48 hours of admission nor was there a comprehensive care plan developed in lieu of the baseline care plan within 48 hours after admission. Interview on 01/17/24 at 4:38 P.M. with the Director of Nursing (DON) confirmed Resident #75's medical record did not have a baseline care plan with interventions within 48 hours of admission nor had a comprehensive care plan been developed within 48 hours of admission in lieu of the baseline care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on record review, observation, resident, family and staff interviews, and review of facility policy, the facility failed to ensure nail care was provided for Resident #23 and timely incontinence care was provided for Resident #35. This affected two residents (#23 and #35) of three residents reviewed for activities of daily livings (ADL). The facility census was 69. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, spinal stenosis, and dependence on wheelchair. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 that indicated Resident #23 was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #23 utilized a wheelchair and was dependent for ADLs. Review of the care plan dated 09/12/23 revealed Resident #23 required extensive assistance for ADL functioning related to cerebral infarction affecting right dominant side that included personal hygiene, bathing, dressing and/or grooming. Observation and interview on 01/16/24 at 11:14 A.M. revealed Resident #23 laying in bed with her right hand laying across her chest. Resident #23's right hand was contracted with the middle and ring fingernails brown in color, thick, brittle, and approximately 1.5 inches in length. Resident #23's thumb, index and pinkie fingernails were yellow in color, thick, and approximately one inch in length. Resident #23's left hand fingernails were well manicured. Resident #23 revealed her nails on her right hand were always long despite asking staff to trim them. Resident #23 revealed staff clipped her nails on her left hand, but did not trim the right hand. Interview on 01/16/24 at 2:59 P.M. with State tested Nurse Assistant (STNA) #241 revealed staff aides were responsible for trimming resident nails. STNA #241 confirmed staff did not trim Resident #23 nails. Interview on 01/17/24 at 8:03 A.M. with Licensed Practical Nurse (LPN) #215 revealed staff did not trim Resident #23 nails. LPN #215 revealed Resident #23's nails were trimmed by her family, friends, and/or her church members. Interview on 01/17/24 at 8:21 A.M. with STNA #200 revealed she never trimmed Resident #23 nails. Interview on 01/17/24 at 12:21 P.M. with the Director of Nursing (DON) revealed STNA's were responsible for trimming fingernails. DON revealed Resident #23 fingernails were too thick for nail clippers utilized by the facility, therefore staff did not trim them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 01/17/24 at 12:40 P.M. with the DON revealed Resident #23's nails were now trimmed as she sat in the dining room. The DON revealed STNA #200 trimmed her nails and was not aware if facility staff had ever attempted to do it before. The DON revealed Resident #23's nails were trimmed with the nail clippers utilized by the facility. Review of the facility document titled Activities of Daily Living (ADL), dated March 2023, revealed the facility had a policy in place to ensure all staff understood the principles of quality of life and honor and support these principles for each resident and that the care and services provided were person-centered and honor and support each resident preferences, choices, values, and beliefs. Further review of the policy revealed the facility would provide hygiene care that included bathing, dressing, grooming, and oral care. Review of the document revealed the facility did not implement the policy. 2. Review of medical record revealed Resident #35 had an admitted [DATE]. Diagnoses included Parkinson's disease without dyskinesia, chronic obstructive pulmonary disease, unspecified protein-calorie malnutrition, and incontinence of bowel and bladder. Review of the comprehensive MDS assessment, dated 11/01/23, revealed the resident had impaired cognition. The resident was dependent for toileting. The resident was identified to be always incontinent of bowel and bladder. Review of the plan of care dated 10/25/23 revealed the resident had functional incontinence related to impaired mobility, weakness, and debilitation. Interventions included to check and change during care rounds (every two hours), wash/rinse, dry perineum, and apply adult brief. Review of the plan of care dated 10/25/23 revealed the resident was at risk for altered skin integrity. Interventions included to apply barrier cream as ordered, pressure reducing devices on chair and bed, and turn every two hours and as needed. Review of the plan of care dated 11/07/23 revealed the resident had altered skin integrity. Interventions included to turn and reposition during care rounds and as needed. Review of pressure ulcer assessments dated 10/26/23 to 11/25/23 revealed the resident was at mild to high risk for pressure ulcers. Review of the incontinence care log for Resident #35 revealed limited information regarding if staff completed incontinence care every two hours. Observations on 01/17/24 from 10:39 A.M. to 2:05 P.M. revealed a delay in incontinence care for Resident #35. At 10:39 A.M. Resident #35 was sleeping while seated in her wheelchair. Observations on 01/17/24 at 11:35 A.M. revealed STNA #200 entered Resident #35's room to assist Resident #35 with taking in fluids. Resident #35 remained asleep. Observations on 01/17/24 at 12:53 P.M. revealed staff brought a lunch tray to Resident #35. Resident #35 remained in her wheelchair having no incontinence care provided. Observations at 01/17/24 1:00 P.M. revealed Resident #35's granddaughter was in to visit. Observation and interview on 01/17/24 at 1:30 P.M. with LPN #235 revealed staff had not completed incontinence care or repositioned Resident #35. LPN #235 stated all residents who were incontinent should be checked/changed and repositioned every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/17/24 at 1:48 P.M. with STNA #200 and #244 revealed incontinence care should be completed every two hours with care rounds but the family didn't want Resident #35 checked and changed every two hours because Resident #35 was tired during the day. Interview on 01/17/23 at 1:51 P.M., with a family member of Resident#35 revealed the family member stated she spoke with the Administrator and DON about not providing care for Resident #35 during the overnight shift due to excessive sleepiness during the day. The family member stated they wanted incontinence care provided during the day hours. Observations on 01/17/23 at 2:05 P.M. revealed STNA #200 and #244 provided incontinence care for Resident #35. Resident #35 had two round areas of skin impairment on her bottom covered with a thick layer of paste. Interview on 01/18/23 at 11:03 A.M., the DON stated incontinence care should be provided during care rounds as needed. Interview on 01/18/23 at 4:00 P.M., with the Assistant Director of Nursing (ADON) #217 verified the incontinence care logs for Resident #35 had limited information regarding if staff completed incontinence care every two hours. Review of facility policy titled AM/PM Resident Care, dated 2022, revealed staff should complete incontinence care during care rounds as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, observation and interview, the facility failed to ensure adequate supervision of Resident #46 to prevent a fall. This affected one resident (46) of two residents reviewed for falls. The facility census was 69. Finding include: Record review was conducted for Resident #46 who was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, visual loss both eyes, visual hallucination, vascular dementia, hypertension, peripheral vascular disease, localized edema, and glaucoma. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/12/23, revealed the resident had clear speech and made self-understood, was cognitively intact, had no known displays of physical or verbal behavior symptoms, exhibited no rejection of care, and her functional range of motion for upper and lower extremities was impaired. Resident #46 required a wheelchair for mobility, maximal assistance for bathing and site to stand, dependent on staff for personal hygiene, substantial assistance was needed for eating and moderate assistance to roll left and right in bed. Resident #46 did not walk 10 feet and had no falls since the prior MDS assessment. A review of Resident #46's care plan,date revised 12/14/23, revealed at risk for falls. Fall prevention intervention included the door will remain open one quarter, encourage use of call light, encourage use of nonskid socks, instruct resident on safety measures, keep call bell in reach. A review of Resident #46 care plan, date revised 12/12/23, revealed a self-care deficit related to hemiplegia and hemiparesis due to cerebral infarction and activities of daily living (ADL) needs including ambulation and transfer assist of one, bathing and hygiene assist of one, dressing and grooming assist of one, toileting assist of one. A review of Resident #46's Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls with a score of 14. Most recent fall was 01/04/24. Resident #46 had severely impaired sight, ambulated with problems, and needed devices. Resident #46 was at risk for falls due to health conditions and medications. A review of Resident #46's progress note written on 01/04/24 revealed the nurse was notified by an aid resident had fallen on the floor in the bathroom. Resident #46 was sitting on the floor in front of the sink on her bottom. Resident denied pain and injury. Nurse assessed resident, vital signs were assessed by the nurse and range of motion was done. Resident #46's son, the doctor and nurse manager were notified. A review of a physician note dated 01/04/24 for an acute visit revealed Resident #46 had an unwitnessed fall. Resident #46 stated she hit her head and denied headaches. Neurology checks were unremarkable. The physician discussed options with resident and family. The facility was to follow unwitnessed fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement dated 01/04/24 by State tested Nursing Assistant (STNA) #283 revealed STNA #283 was helping Resident #46 brush her teeth, turned around to set up the wheelchair and Resident #46 fell on to her butt to the floor after her knee got weak and buckled. Interview on 01/18/24 at 9:25 A.M. with the Director of Nursing (DON) revealed the STNA #283 had set Resident #46 up in the bathroom to brush her teeth, then the STNA left the resident alone to go make the resident's bed. The DON verified Resident #46 was left alone in the bathroom and fell , and Resident #46 was a standby assist for care. The DON stated the STNA was terminated due to leaving Resident #46 alone in the bathroom. An interview was conducted on 01/18/24 at 10:02 A.M. with Resident #46 who revealed she fell because she could not find the grab bar by the sink. Resident #46 stated no staff was in the bathroom with her so she fell . Interview on 01/18/24 at 10:06 A.M. with STNA # 260 revealed Resident #46 was a transfer assist of one-person, one-person assistance needed for oral hygiene and resident was not to stand alone. Interview on 01/18/24 at 10:11 A.M. with Licensed Practical Nurse (LPN) # 302 revealed Resident # 46 was a one-person assistance with transfers and if the resident was at the sink in the bathroom she would need to sit in her wheelchair for safety. LPN #302 stated Resident #46 should not be left alone while standing. Review of facility policy titled Activities of Daily Living ,revision date March 2023, revealed resident care was based on the comprehensive assessment of the resident and consistent with the resident's needs and choices, the facility would provide the necessary care and services. Review of the facility policy titled Fall Management, revision date of December 2022, revealed the facility would identify each resident who was at risk for falls and would develop a plan of care and implement interventions to manage falls.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on observations and interview the facility failed to date insulin pens when opened. This affected four (Resident #4, #5, #36, and Resident #51) of five residents reviewed for medication storage. The facility census was 69. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed the resident had intact cognition. Review of physician orders revealed an order for lispro injection solution dated [DATE]. Review of the Medication Administration Record (MAR) revealed Resident #4 received lispro injection of four units on [DATE]. 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included diabetes mellitus. Review of the comprehensive MDS 3.0 assessment, dated [DATE], revealed the resident had intact cognition. Review of physician orders revealed an order for Humalog solution dated [DATE]. Review of the MAR revealed Resident #5 received five units of Humalog on [DATE]. 3. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included diabetes mellitus. Review of the comprehensive MDS 3.0 assessment, dated [DATE], revealed the resident had impaired cognition. Review of physician orders revealed an order for Humalog solution dated [DATE]. Review of the MAR revealed Resident #36 received two units of Humalog on [DATE]. 4. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included diabetes mellitus. Review of the comprehensive MDS 3.0 assessment, dated [DATE], revealed the resident had intact cognition. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed an order for Lispro solution dated [DATE]. Review of the MAR revealed Resident #51 received five units of Lispro on [DATE]. Observation was conducted on [DATE] at 2:15 P.M. of the insulin pens for Resident #4, #5, #36 and #51 and revealed the pens were opened but not dated with the open date. Interview was conducted on [DATE] at 2:15 P.M. with Licensed Practical Nurse (LPN) #235 during the observation of the insulin pens. LPN #235 verified the insulin pens were not dated to indicate the first day the insulin was used for Resident #4, #5, #36 and #51. Review of facility policy titled Vials and Ampules of Injection Medications, dated 2023, revealed staff must record date opened and date expired on all multidose vials.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 42730 Based on observation, staff interview, and policy review, the facility failed to ensure mechanically altered diets were prepared to a proper consistency to ensure safe consumption. This had the potential to affect eleven Residents (#3, #9, #19, #30, #33, #34, #35, #37, #49, #327, #379) who were identified by the facility to have a minced and moist mechanically altered diet order. The facility census was 69. Findings include: Observation and interview during the mechanical altered food preparation on 01/16/24 at 11:46 A.M. revealed Dietary [NAME] (DC) #249 being informed to prepare the mechanical soft honey garlic chicken by Dietary Manager (DM) #814. DC #249 was observed grabbing five pieces of chicken and placing it on a white cutting board. DC #249 was observed using a handheld knife to hand chop up the chicken and place it in a serving dish for the steam table. Observation revealed the chicken pieces were chopped by hand and were approximately one inch by one inch in size. DC #249 revealed she was allowed to prepare all mechanically altered diets by hand, except the pureed diets. DC #249 revealed the knife utilized was sharp enough to chop the chicken up small enough for consumption and the food processor was not needed. DC #249 confirmed and verified there were multiple forms of mechanically altered diets and the facility had a food processor in place to assist with meal preparation, but all mechanically altered meals, after being hand chopped, had gravy added. Interview on 01/17/24 at 9:47 A.M. with Registered Dietician (RD) #818 revealed a food processor was to be used for all mechanically altered diets, including pureed, mechanical soft, and minced and moist. Interview with the Director of Nursing (DON) on 01/18/24 at 12:39 P.M. revealed if a resident had a mechanically altered diet, including minced and moist, the facility just added gravy and there was no policy followed for specific sizes. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) dated 2018, revealed mechanically altered, ground, pureed, and/or minced and moist diets had different consistencies to decrease difficulty in swallowing. Review of the IDDSI revealed pureed diets required no chewing, could be eaten with a spoon, could not be drank from a cup or straw; minced and moist was to be 4 millimeters (mm) in size, fit between a fork prong, moist with thick gravy, and could be eaten with a fork. Review of the facility document titled Dietary Policy and Procedure Manual: Keeping Food Safe undated, revealed the facility had a policy in place that food should be provided in a consistency the resident can tolerate safely. Further review of the policy revealed some residents had dysphasia that affected their ability to swallow, and certain consistencies could place the individual at risk for aspiration and food and beverage restrictions should be checked. Review of the document revealed the facility did not implement the policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42730 Based on observation, staff interview, and facility policy review, the facility failed to ensure food was served in a sanitary manner and food was stored and dated properly. This had the potential to affect 67 of 69 residents receiving food from the kitchen. The facility identified Residents #63 and #73 as not receiving food from the kitchen. The facility census was 69. Findings include: An initial tour of the kitchen was conducted on 01/16/24 between 9:30 A.M. and 10:35 A.M. with Dietary Manager (DM) #814. The following was observed and verified at the time of observation. In the dry storage area, one bag of hot cocoa, one bag of brown sugar, and one bag of biscuit mix was undated, and one bag of food thickener was open to air, unsealed. In the walk-in fridge, a container of cooked rice was open to air. In the walk-in freezer, one bag of hash browns, one box of frozen chicken, one bag of celery, and one bag of green peppers were open to air and undated. During the follow-up tour of the kitchen on 01/16/24 at 11:29 A.M. at the time of tray line, DM #814 was observed checking the temperature of food items located on the steam table. DM #814 was observed using a handheld thermometer to obtain temperature of the parsley noodles and honey garlic chicken. DM #814 used a white napkin to clean the thermometer after each temp check. No alcohol preparation pad or sanitation cloth was used. DM #814 confirmed and verified the findings at the time of the observation. Observation and interview on 01/16/24 at 11:41 A.M. revealed Dietary [NAME] (DC) #249 touching and adjusting her black surgical mask then reached down and gathered multiple hot plates to prepare to serve food. DC #249 confirmed and verified the findings at the time of the observation. Observation and interview on 01/16/24 at 11:56 A.M. revealed Dietary Aide (DA) #250 had uncovered and noticeable facial hair exposed while assisting with tray line. DA #250 confirmed and verified the findings at the time of the observation. Review of the facility document titled Food Handling undated, the facility had a policy in place that food items that were open to air, not labeled or dated, would not be served. Review of the policy revealed the facility did not implement the policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38523 Based on observation and interview, the facility failed to ensure staff removed gloves after emptying a catheter and before proceeding to touch Resident #49's personal items. This affected one resident (#49) of 20 residents reviewed for infection control. The census was 69. Findings include: Observation was conducted on 01/17/24 at 2:36 P.M. of State tested Nursing Assistant (STNA) #237 emptying Resident $49's urinary catheter bag. STNA #237 emptied the urine from the catheter bag and did not remove her gloves after completing the task. STNA #237 came back out of Resident #49's bathroom with the same gloves on and adjusted his bedside table closer to him, straightened his personal belongings on top of the table and pushed his newly opened bottle of water closer to him to be in his reach. Interview on 01/17/24 at 2:38 P.M. with STNA #237 confirmed she completed emptying Resident #49's catheter bag and did not remove her gloves or wash her hands after the task and before handling Resident #49's personal items.